



South Carolina Department of Labor, Licensing and Regulation

Board of Medical Examiners

Synergy Business Park, Kingstree Building
110 Centerview Drive
Post Office Box 11289
Columbia, SC 29211
(803) 896-4500



APPLICATION FOR A LIMITED LICENSE

Complete all sections of this application by providing all of the requested information. You must notify the Board in writing within fifteen (15) business days of any address changes after you file this application in order to receive information from the Board. This application form is a public document obtainable under the Freedom of Information Act.

PART I: Applicant Identifying Information					
1. Last Name	2. First Name	3. Middle Name	4. Suffix (Jr., III)		
5. Title <input type="checkbox"/> M.D. <input type="checkbox"/> D.O.		6. Maiden Name			
7. Mailing Address (Street or PO Box, City, State, Zip)					
8. Home Address (Street, City, State, Zip – not PO Box)					8a. Home Congressional District
8b. Home Phone		8c. Home Fax		8d. Home Email	
9. Business Name		9a. Business Address (Street, City, State, Zip – not PO Box)			
9b. Business Phone		9c. Business Fax		9d. Business Email	
10. Place of Birth (List City & State or Country)	11. Date of Birth MM/DD/YYYY	12. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	13. Race (For Statistical Purposes Only) <input type="checkbox"/> African American/Black <input type="checkbox"/> Hispanic/Spanish Origin <input type="checkbox"/> American Indian <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Asian/Oriental <input type="checkbox"/> Other		
PART II: Education Information					
SCHOOL NAME	LOCATION (City, State & Country)	DATES OF ATTENDANCE		GRADUATED Yes/No	HIGHEST GRADE COMPLETED OR DEGREE EARNED
		FROM (Month/Year)	TO (Month/Year)		
Professional Education					
List in chronological order from date of graduation to the present <u>all</u> professional education. Do not include continuing education coursework, apprenticeship, intern, residency, vocational training practical or clinical training.					
INSTITUTION NAME	LOCATION (City, State & Country)	DATES OF ATTENDANCE		DID YOU COMPLETE PROGRAM	DEGREE EARNED
		FROM (Month/Year)	TO (Month/Year)		
				Y <input type="checkbox"/> N <input type="checkbox"/>	
				Y <input type="checkbox"/> N <input type="checkbox"/>	
				Y <input type="checkbox"/> N <input type="checkbox"/>	
				Y <input type="checkbox"/> N <input type="checkbox"/>	

*The Social Security Number (SSN) is not subject to disclosure as public information. The disclosure of the SSN for identification purposes is authorized and mandated by federal statutes requiring state boards to report to the Healthcare Integrity and Protection Data Bank (HIPDB) and the National Practitioner Data Bank (NPDB), among other things. (Revised 7/10/12)

Are you a graduate from a program outside the United States?	YES <input type="checkbox"/> NO <input type="checkbox"/>
Was your medical education interrupted other than for vacation periods? If yes, attach a written explanation.	YES <input type="checkbox"/> NO <input type="checkbox"/>

PART III: Internship and Residency Training Information

Complete the requested information below on all training programs completed in the US or Canada. Failure to disclose any training program information may result in the denial of your application or other appropriate action.

SCHOOL NAME	LOCATION (City, State & Country)	DATES OF ATTENDANCE		GRADUATED Yes/No
		FROM (Month/Year)	TO (Month/Year)	

PART IV: Record of Examination(s)

Complete the requested information below if licensure examination was taken in this state or any other state. List each examination attempt below, use additional sheets if necessary. Failure to disclose an examination attempt may result in the denial of your application or other appropriate action.

Name of Examination(s)	State or Country	Date of Examination	Passed/Failed/Score (If score, enter score)

PART V: Record of Licensure

Complete the requested information below if you have ever been licensed to practice in any profession or occupation. You must identify the method by which you obtained your license(s) and include jurisdiction both within and outside the United States current or inactive. Failure to disclose all licenses held may result in denial of your application or other appropriate action. (Attach additional sheets if necessary.)

Jurisdiction	Credential Type (MD or DO)	License Number/Name on License	How License Obtained (Type of Exam or Endorsement)	Date issued
State of Original (Initial) Licensure:				
List Other Jurisdictions of Licensure:				

PART VI: Medical Specialty and South Carolina Location Information

1. Current medical specialty/training _____

2. South Carolina location: _____

Hospital/Clinic name

Street Address

City

State

Zip

3. Certified/recertified by American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA):

Board name _____ Year _____

Attach copies of American Specialty Board Certificates (ABMS or AOA)

4. Branch of military service _____ date of service _____ type of discharge _____

Attach a copy)

PART VII: Letters of Recommendation

Please supply below names and addresses of three physicians willing to supply these letters of recommendation to support your application for South Carolina medical licensure. **You must request that each physician listed below write directly to the Board (on letterhead)** indicating that you are known to them, in what capacity and for how long, and outlining characteristics they believe qualify you for medical licensure in South Carolina. **Your application will not be considered complete until letters of reference from the three physicians identified below and all other materials necessary to support your application have been received.**

1. Name _____ telephone () _____

Address _____ City, State, Zip _____

2. Name _____ telephone () _____

Address _____ City, State, Zip _____

3. Name _____ telephone () _____

Address _____ City, State, Zip _____

PART VIII: Medical Practice/Employment History

List all related employment chronologically most recent first, for the past five (5) years. If you have never been employed in the profession you are applying for, insert "N/A" for Not Applicable. Photocopy this form if additional space is required.

1. Company Name		Company Address (Street, City, State, Zip)	
Job Title	Type of Employment	Date of Employment	
	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	From: _____ To: _____	
Abbreviated Description of Duties Performed	Hours Worked per Week	Reason for leaving	
2. Company Name		Company Address (Street, City, State, Zip)	
Job Title	Type of Employment	Date of Employment	
	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	From: _____ To: _____	
Abbreviated Description of Duties Performed	Hours Worked per Week	Reason for leaving	
3. Company Name		Company Address (Street, City, State, Zip)	
Job Title	Type of Employment	Date of Employment	
	<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	From: _____ To: _____	
Abbreviated Description of Duties Performed	Hours Worked per Week	Reason for leaving	

PART IX: Personal History Information

If you answer “yes” to any of the questions below (1-15), you must attach a full written explanation pertaining to that particular question.

1. Has your medical license ever been revoked, suspended, reprimanded, restricted or placed on probation by a medical licensing board or other entity?	YES <input type="checkbox"/> NO <input type="checkbox"/>
2. Have you ever had an application to practice medicine denied or refused by another medical licensing board or other entity?	YES <input type="checkbox"/> NO <input type="checkbox"/>
3. Have you ever had any hospital privileges denied, revoked, suspended or restricted in any way?	YES <input type="checkbox"/> NO <input type="checkbox"/>
4. Have you ever voluntarily surrendered a medical license, controlled substance registration or DEA registration?	YES <input type="checkbox"/> NO <input type="checkbox"/>
5. Have you ever resigned from any hospital, institution or health care facility in lieu of disciplinary action?	YES <input type="checkbox"/> NO <input type="checkbox"/>
6. Are you currently under investigation or the subject of pending disciplinary action by any Medical Licensing Board, health care facility or other entity?	YES <input type="checkbox"/> NO <input type="checkbox"/>
7. Is your medical license currently restricted in any way or have you ever been fined by any medical licensing board, or other entity?	YES <input type="checkbox"/> NO <input type="checkbox"/>
8. Have you ever had a malpractice lawsuit, judgment or settlement filed against you? If yes, how many? _____ (Complete the attached malpractice form, if applicable)	YES <input type="checkbox"/> NO <input type="checkbox"/>
9. Currently or within the last ten years, have you been treated for any physical, mental or emotional condition that might interfere with your ability to competently and safely perform the essential functions of practice as a physician?	YES <input type="checkbox"/> NO <input type="checkbox"/>
10. Currently or within the last ten years, have you developed any disease or conditions, physical, mental or emotional, (e.g. bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder) that might interfere with your ability to competently and safely perform the essential functions of practice?	YES <input type="checkbox"/> NO <input type="checkbox"/>
11. Has your ability to practice medicine ever been impaired by any physical or mental illness or by the use of alcohol or drugs?	YES <input type="checkbox"/> NO <input type="checkbox"/>
12. Have you ever discontinued the practice of medicine for any reason for one month or more?	YES <input type="checkbox"/> NO <input type="checkbox"/>
13. Has your ability to prescribe controlled substances ever been denied, revoked, suspended, or limited by any hospital, health care facility or other entity?	YES <input type="checkbox"/> NO <input type="checkbox"/>
14. Currently or within the last ten years, have you been arrested, indicted, or convicted, pled guilty, or pled <u>nolo contendere</u> for violation of any federal, state, or local law (other than a minor traffic violation)?	YES <input type="checkbox"/> NO <input type="checkbox"/>
15. Have you ever been known by any other name or surname?	YES <input type="checkbox"/> NO <input type="checkbox"/>

For Board Member use only_____
Applicant Signature_____
Date_____
Board Member Signature_____
Date

PART X: Certifying Statement

I, _____ being duly sworn, depose and say that I am the person described and identified, that I am of good moral character and that I am the person named in the documents presented in support of this application. By filing this application, I hereby authorize and consent to an investigation of my fitness and qualifications to practice medicine in South Carolina.

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state and federal) to release to this licensing Board any information, files or records requested by the Board for its evaluation of my professional, ethical and other qualifications for licensure in South Carolina. I hereby release, discharge and exonerate the State Board of Medical Examiners of South Carolina, its agent or representative and any person or organization furnishing information from any and all liability of every nature and kind arising out of the furnishing of documents, records or other information, or arising from the investigation made by the State Board of Medical Examiners of South Carolina.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare that all statements made by me herein are true and correct. Should I furnish any false or incomplete information in this application, I hereby agree that such an act shall constitute the cause for denial or revocation of my license to practice medicine in South Carolina. Further, if licensed, I agree to keep the Board informed of any future changes in my address.

I hereby authorize the Board of Medical Examiners of South Carolina to utilize my Social Security Number in making necessary reports to the Federation of State Medical Boards' Physician Data Center for compilation of information about applicants and licensees in order to coordinate licensure and disciplinary activities between the individual States' licensing boards.

Signature of Applicant (Do not print)

Printed Name of Applicant

Date

Subscribed and sworn to before me this _____ day of

_____, _____.

Notary Public Signature

My Commission Expires: _____

Attach professional photo here

(2x2)

Passport size

No copies

Do Not Staple

RIGHT THUMB PRINT

If right thumb is missing, use left and so indicate

For Office Use Only

Date Received: _____

Paid by: ☐ Check ☐ Money Order ☐ Cash

Check/Money Order No: _____ Amount: _____

Control No. _____ Deposit No. _____

AFFIDAVIT OF ELIGIBILITY

Pursuant to section 8-29-10 of the South Carolina Code of Laws (1976 as amended), the Department of Labor, Licensing and Regulation must verify the lawful U.S. presence of any person who applies for a South Carolina license. Please complete and sign this affidavit of eligibility. The information provided is subject to verification.

Section A: LAWFUL PRESENCE in the United States.

I, (please print your full name) _____, swear or affirm under penalty of perjury under the laws of the State of South Carolina that (check 1, 2 or 3 below):

1. ____ I am a United States citizen or legal permanent resident eighteen years of age or older; or
2. ____ I am not a US citizen but am lawfully present in the US as evidenced by one of the following
 - a. ____ I am a qualified alien as defined in 8 U.S.C. sec 1641, eighteen years of age or older.
 - b. ____ I am a nonimmigrant under the "Immigration and Nationality Act,"
Federal Public Law 82-414 as amended, eighteen years of age or older.
3. ____ I am not physically present in the US under 8 U.S.C. sec 1621 (c) (2) (c) or employed in the US pursuant to 8 U.S.C. 1621 (c) (2) (a) (check either a or b below):
 - a. ____ I am a US citizen, not physically present or employed in the United States.
 - b. ____ I am a Foreign National, not physically present or employed in the United States.

If you selected either 3.a. or 3.b., you do not need to complete Section B. Skip to Section C.

Section B: Secure and Verifiable Document. This section must be completed if you checked number 1 or 2 in Section A.

1. Please check one of the following acceptable secure and verifiable documents. Complete documentation must be provided.

- ☐ Any valid South Carolina Driver's License, South Carolina Driver's Permit or South Carolina Identification Card? Number _____; Date of Expiration: _____
- ☐ Any valid out-of-state issued photo Driver's License or photo identification card, photo driver's permit? State: _____; Number _____; Date of Expiration: _____.
- ☐ Permanent Resident Card; Alien Number _____; Card Number _____; Date of Expiration: _____.
- ☐ Employment Authorization Card; Alien Number _____; Card Number _____; Date of Expiration: _____
- ☐ Certificate of Naturalization with intact photo.
- ☐ Certificate of (US) Citizenship with intact photo.
- ☐ Other: (Name of verifiable document) _____

2. Enter the state or the federal agency name where this secure and verifiable document was issued.

(If issued by a state agency, include both the state and agency name.)

3. Please provide your social security number: _____/_____/_____

Section C: Attestation.

- I understand that this sworn statement is required by law because I have applied for or seek reinstatement of a professional or commercial license as provided for in 8 U.S.C. §1621. I understand that state law requires me to provide proof that I am lawfully present in the United States.
- I understand that in accordance with section 8-29-10 of the South Code, a person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a felony.
- I am the person identified above, and the information contained herein is true and correct to the best of my knowledge. I understand that under South Carolina law, providing false information is grounds for denial, suspension or revocation of a license, certificate, registration or permit.

Signature

Date

Please print your name as shown on your secure and verifiable document.

Professional License Type: _____

License Number (if already licensed): _____

The South Carolina Law requires that every individual who applies for an occupational or professional license provide a social security number for use in the establishment, enforcement and collection of child support obligations and for reporting to certain databanks established by law. Failure to provide your social security number for these mandatory purposes will result in the denial of your licensure application. Social security numbers may also be disclosed to other governmental regulatory agencies and for identification purposes to testing providers and organizations involved in professional regulation. Your social security number will not be released for any other purpose not provided for by law.

06/28/12 Affidavit of Eligibility



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Applicant's Name _____
First Middle Last

I am applying for a license to practice medicine in the state of South Carolina. Please complete this form and forward an original graduate transcript bearing the institution's official seal to the address listed above.

Applicant's Signature

Date

CERTIFICATION OF MEDICAL OR OSTEOPATHIC EDUCATION

(Medical School is requested to complete this insert with the school seal and send copies of medical school transcript certified by the medical school to South Carolina Board of Medical Examiners.)

It is hereby certified that _____
of (hometown, state and country) _____
attended (full name of school) _____
from _____ to _____ and received a diploma conferring the
degree of _____ and said diploma bears the
following date _____.

A certified copy of this applicant's transcripts is enclosed.

(SEAL)

Current date

(Dean, Registrar, President)



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TO: Physicians Applying for Limited License for Postgraduate Training
Department Chairman or Training Directors

FROM: LLR- Board of Medical Examiners

SUBJECT: Responsibility of the South Carolina Supervising Physician

Physicians applying for a Limited License in South Carolina for postgraduate training must complete Part I (below) and the Chairman or Training Director of your South Carolina residency program must complete Part II (next page).

Part I: (To be completed by Limited License Applicant)

Name: _____
First Middle Last

Name of Training Hospital: _____

Name of Training Program: _____

Name of Department Chairman or Training Director: _____

Entering _____ year of training in _____
(1st, 2nd, etc.) (Specialty)

Applicant's signature: _____ Date: _____

Part II: (To be completed by Department Chairman or Training Director in South Carolina)

The individual physician, whose name appears in Part I, has applied for a Limited License for postgraduate training. As Department Chairman or Training Director, you are this applicant's supervising physician. As such, you have certain responsibilities to the Board. This document will summarize current law and your legal responsibilities as supervising physician.

1. A physician in a residency training program must possess a valid license before beginning to practice. It is a violation of state law if a physician practices in a training program before being issued a license.
2. This applicant has applied for a Limited License. Limited Licenses are valid only for the fiscal year (July 1-June 30) or part thereof, and must be renewed. It is a violation of state law for a physician to practice on an expired Limited License.
3. If a resident engages in practice without a valid, active license, the Department Chairman, Training Director and other supervising physicians are subject to discipline under the Medical Practice Act for assisting an unlicensed person to practice medicine (Section 40-47-110 {B}{12}).
4. There are several specific restrictions on a Limited License. A Limited License is restricted to practicing only within the residency training program. Moonlighting on a Limited License is strictly forbidden and a violation of state law. A Limited License is issued for a specific training program and is not transferable to another training program or department.
 - I acknowledge and understand my responsibilities as supervisor of the individual applicant, whose name and signature appear on this form.
 - I understand that any physician practicing medicine in a residency training program must possess an active, valid license in South Carolina. If a resident engages in unlicensed practice, I, as a supervising physician, am subject to discipline under the Medical Practice Act.
 - I further agree that if this applicant is subject to adverse action within our residency training program as a result of unprofessional, unethical or illegal conduct, that I shall report such action in writing to the S.C. Department of Labor, Licensing and Regulation, Board of Medical Examiners.

Date_____
Signature of the South Carolina Chairman or Director_____
SC License #_____
Print name

(After completion of form, return to LLR- Board of Medical Examiners)



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MALPRACTICE CLAIM INFORMATION

This form must be completed if you have ever been named as a defendant in a malpractice lawsuit, verdict or settlement.

Physician name

Office telephone no.

Address

City

State

Zip

MALPRACTICE COMPLAINT: (Include name of patient, age, sex, date of occurrence and location, i.e., office or name and address of hospital.)

Patient's Name: _____

Age: _____ Sex: _____

Date/place of occurrence: _____

Indicate your position in case, i.e., resident, primary physician, etc.: _____

FILED AGAINST:

() Individual Doctor

() Group

() Hospital

List names of other defendant-doctors and/or hospitals:

DISPOSITION:

() Pending

() Jury Verdict

() Settled

() Dismissed

() Dropped

If there has been a verdict or settlement, please provide the following information:

Legal outcome: _____

Date: _____ Total amt.
paid (if any): _____

Amount attributable to you: _____

1. On a separate sheet, provide a detailed written explanation of the background and medical issues involved in the case.
2. Attach copies of the complaint, answer, release, settlement documents and all other relevant legal documents.
3. Form may be duplicated as needed. A separate report must be completed for each malpractice claim.

Date: _____ Signature: _____



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VERIFICATION OF LICENSURE

Complete the top portion of this form and forward a copy to each state board by which you are now or ever been licensed to practice medicine. You may want to contact each state to see if a fee is required.

In applying for a license to practice medicine in the State of South Carolina, the Board of Medical Examiners requires this form to be completed by each state wherein I hold or have ever held a license. My signature below is your authority to release any and all information in your file, favorable or otherwise, regarding me directly to the above address.

PLEASE TYPE OR PRINT

Signature _____

Name _____

Address _____

City _____ State _____ Zip _____

DO NOT DETACH

This section should be completed by an official of the state board and returned directly to the South Carolina Board of Medical Examiners.

Full name of licensee: _____

Graduate of: _____ Date of degree: _____

State of: _____ License number: _____ Date issued: _____

Licensed by: ☐ National Board ☐ FLEX Exam ☐ USMLE
 ☐ State Board Exam ☐ Other _____

License is current _____ If no, why not? _____

Has license been suspended, revoked, or restricted? _____ If yes, why? _____

Comments, if any _____

Date: _____

Signature: _____

Board Seal

Title: _____

State Board: _____